	Items	Prior Year (Actual)	Current Year (Budget)	Budget Year (Budget)
A.	Pass-through costs			
(1)	Depreciation			
(2)	Rents and leases			
(3)	Property taxes			
(4)	Property insurance			
(5)	Interest			
(6)	Malpractice insurance			
(7)	Total Pass-Through Costs (Subitems (1) to (7))			
B.	Total charges billed to all payers for inpatient hospital services			
C.	Total admissions for all payers			
D.	Total days of inpatient hospital services for all payers			
E.	Total MA AFDC admissions			
F.	Total MA non-AFDC admissions			
G.	Total GAMC admissions			

Pass-through costs are limited to item A, as determined by medicare. Pass-through costs do not include costs derived from capital projects requiring a certificate of need for which the required certificate of need has not been granted.

A hospital shall submit to the department a copy of the HCFA Form 2552 and the amended HCFA Form 2552 that the hospital submits to medical assistance. An HCFA Form 2552 or an amended HCFA Form 2552 must be submitted to the department within ten working days of the day on which the form is submitted to medicare.

If medicare stops requiring HCFA Form 2552 or if the medicare/medical assistance cost report required by medicare no longer identifies capital or malpractice insurance costs in a way that is consistent with the 1985 version of HCFA Form 2552, the department may require a hospital to continue to complete and submit to the department the 1985 version of HCFA Form 2552, Worksheet D-8, part I; and Worksheet D, parts I and II.

Subp. 2. Determination of budget year pass-through cost per admission. The department shall determine the budget year pass-through cost per admission from the submitted pass-through cost report as specified in subpart 1 as follows:

	Items	Prior Year (Actual)	Current Year (Budget)	Budget Year (Budget)
A.	Ratio of reimbursable inpatient hospital costs as determined in part 9500.1115, item A to total reimbursable costs			
B.	Pass-through costs as specified in subpart 1, item A, subitem			

(7), multiplied by item A			
C. Number of Medical Assistance admissions including outliers			
D. Pass-through cost per admission (item B divided by item C)			

Subp. 3. **Categorical rate per admission.** The department shall determine the categorical rate per admission as follows:

Categorical Rate Per Admission = [(Adjusted base year cost per admission multiplied by the budget year HCI and multiplied by the relative value of the appropriate diagnostic category), plus the budget year pass-through cost per admission]

Subp. 4. **Pass-through cost adjustment.** After the end of each budget year, the commissioner shall redetermine the budget year pass-through cost payable by medical assistance for that budget year for a Minnesota hospital as follows:

A. For each routine service, divide the capital costs as determined on HCFA Form 2552 by the total number of days of inpatient hospital service for all payers; for example, on the 1985 version of Form 2552, on Worksheet D, Part I, divide column 1 by column 5 for each routine service type. This determination produces an allowable per-day capital cost for each routine service type.

B. Multiply the allowable per-day capital cost for each routine service type as determined in item A by the number of medical assistance days of inpatient hospital services covered during the year for the corresponding routine service type. This determination produces an allowable medical assistance share of the allowable capital costs allocated to each type of routine service.

C. Determine the ratio of overall allowable capital costs to total charges for each type of ancillary service; for example, on the 1985 version of HCFA Form 2552, on Worksheet D, Part II, divide column 1 by column 5 for each type of ancillary service. Then multiply each ratio by the medical assistance charges billed during the year for the corresponding type of ancillary service. This determination produces an allowable medical assistance share of the allowable capital costs allocated to each type of ancillary service.

D. Determine the allowable medical assistance share of malpractice insurance costs, using the current method identified in HCFA Form 2552, Worksheet D-8; for example, from the 1985 version of HCFA Form 2552, Worksheet D-8, Part I, Column 3, line 1.

E. Sum the allowable medical assistance shares of capital costs and malpractice costs determined in items B to D to get the total medical assistance share of the hospital's allowable pass-through costs for the year.

F. Multiply the actual number of medical assistance admissions to the hospital during the year times the budgeted pass-through cost per-admission used in paying claims for inpatient hospital services during the year for which the adjustment is being calculated.

G. Subtract the amount determined at item F from the medical assistance share of allowable pass-through costs for the completed year. The remainder is the pass-through cost

adjustment payable to the hospital. Negative amounts must be deducted by the department from future payments to the hospital or paid to the department by the hospital separately within 60 days of final determination of the amount owed. Positive amounts must be paid by the department to a hospital within 60 days of final determination of the amount owed. If a hospital is required by the commissioner to make separate payments of adjustment amounts owed to the department, those payments must be made within 60 days of the date of notification.

H. Amounts owed by or to the department shall earn interest at the rate charged at that time by the commissioner of the Department of Revenue for late payment of taxes, beginning for the department on the 61st day following determination of an amount owed to a hospital, and for a hospital on the 66th day following the day of the determination of the amount owed by the hospital, but no interest shall be charged to a hospital unless an explicit request for separate payment has been made by the commissioner.

Subp. 5. [Repealed, 11 SR 1688]

Subp. 6. Effective date. The categorical rate per admission; out-of-area categorical rate per admission; categorical rate per admission for MSA or non-MSA hospitals that do not have admissions in the base year; transfer reimbursement; and an outlier reimbursement if appropriate, shall be effective for all admissions that occur on or after July 29, 1985.

MS s 256.969 subds 2,6

10 SR 227; 11 SR 1688

9500.1126 RECAPTURE OF DEPRECIATION.

Subpart 1. Recapture of depreciation. The commissioner shall determine the recapture of depreciation due to a change in the ownership of a hospital that is to be apportioned to medical assistance, using methods and principles consistent with those used by medicare to determine and apportion the recapture of depreciation.

Subp. 2. Payment of recapture of depreciation to commissioner. A hospital shall pay the commissioner the recapture of depreciation within 60 days of written notification from the commissioner.

Interest charges must be assessed on the recapture of depreciation due the commissioner outstanding after the deadline. The annual interest rate charged must be the rate charged by the commissioner of revenue for late payment of taxes in effect on the 61st day after the written notification.

MS s 256.969 subds 2,6

10 SR 227; 11 SR 1688

9500.1130 REIMBURSEMENT PROCEDURES.

Subpart 1. Submittal of claims. Claims may be submitted to the department after a recipient is discharged or after 30 days, whichever occurs first. A hospital that submits a claim to the department after 30 days from admission but before discharge shall submit a final claim after discharge, but must not submit any other interim claims except as part of an appeal.

Subp. 2. Required claims. Hospitals must submit complete medical assistance claims to the department on forms or computer tapes approved by the department. These claims must be

completed according to department instructions. The charge amounts shown must be based on a hospital's usual and customary charges for the inpatient hospital services billed regardless of the hospital's anticipated reimbursement by the department.

Subp. 3. **Reimbursement in response to submitted claims.** The department will reimburse a hospital for inpatient hospital services only after processing that hospital's properly submitted claim. Except as provided in parts 9500.1150 and 9500.1155, the department shall reimburse a hospital a categorical rate per admission; out-of-area categorical rate per admission; categorical rate per admission for MSA or non-MSA hospitals; or transfer reimbursement, and an outlier reimbursement if appropriate.

Subp. 4. **Adjustment to reimbursement.** Reimbursements shall be adjusted by the department for the reasons specified in subpart 5 and for inappropriate utilization as determined by the commissioner under parts 9505.0500 to 9505.0540 and parts 9505.1910 to 9505.2020 and as otherwise provided by law. Adjustment to a hospital's account shall be according to parts 9505.0500 to 9505.0540.

Subp. 5. **Rejection of claims.** Claims shall be rejected by the department for the reasons specified in items A and B.

A. Claims will not be reimbursed if the hospital fails to:

(1) obtain prior authorization;

(2) provide documentation of a confirming second surgical opinion;

(3) receive admission certification; or

(4) assign a claim to one of diagnostic categories in part 9500.1100, subpart 20.

B. Claims will not be reimbursed if inpatient hospital services also covered under Medicare have already been denied under Medicare, on grounds other than medical necessity.

Subp. 6. **Medicare crossover claims.** Medicare crossover claims shall be reimbursed as follows:

Medicare Crossover Reimbursement	=	Medicare deductibles, plus Medicare coinsurance less recipient resources and amounts owed by third parties

Subp. 7. **Reimbursement for transfers.** Reimbursement for transfers shall be made as specified in items A and B.

A. Except as specified in item B, the department shall reimburse both the hospital that discharges a recipient for purposes of transfer and the hospital that admits the recipient who is transferred. Each hospital shall be reimbursed as follows:

Transfer Reimbursement	=	[((The product of the adjusted base year cost per admission and the budget year HCI multiplied by the relative value of the appropriate diagnostic category, divided by the arithmetic

mean length of stay of the diagnostic category) and multiplied by the number of days of inpatient hospital services), plus the budget year pass-through cost per admission)

In no case of a transfer may a hospital receive a reimbursement that exceeds the applicable categorical rate per admission, or out-of-area categorical rate per admission, or the categorical rate per admission for MSA or non-MSA hospitals that do not have admissions in the base year, unless that admission is an outlier. Reimbursements for transfers under diagnostic category O, under part 9500.1100, subpart 20, are not limited to the categorical rate per admission, the out-of-area categorical rate per admission, or the categorical rate per admission for MSA or non-MSA hospitals statewide that do not have admissions in the base year and such admissions are not eligible for outlier reimbursements under subpart 9.

A hospital that admits a transfer recipient is not eligible for a transfer reimbursement under item A unless the inpatient hospital stay continues to be medically necessary.

B. A discharging hospital is not eligible for a transfer reimbursement under item A for services provided to a discharged recipient if the admission to the discharging hospital was not due to an emergency, as defined in part 9505.0500, subpart 11, and the discharging hospital knew or had reason to know at the time of admission that the inpatient hospital services that were medically necessary for treatment of the recipient were outside the scope of the hospital's available services and the readmission to another hospital resulted because of the recipient's need for those services.

Subp. 8. **Reimbursement for readmissions.** An admission and readmission to the same or a different hospital shall be eligible for reimbursement according to the criteria in parts 9505.0500 to 9505.0540.

Subp. 9. **Reimbursement for outliers.** The department shall reimburse a hospital for outliers with the applicable categorical rate per admission, out-of-area categorical rate per admission, or the categorical rate per admission for a MSA or non-MSA hospital that does not have admissions in the base year, plus an amount for outliers as follows:

A. To determine reimbursements for day outliers the department shall:

(1) multiply a hospital's adjusted base year cost per admission by the budget year HCI and by the relative value of the appropriate diagnostic category;

(2) divide the product in subitem (1) by the arithmetic mean length of stay for the diagnostic category;

(3) multiply the per day amount as determined in subitem (2) by 60 percent for diagnostic categories A to N, and P to II, under part 9500.1100, subpart 20 or 80 percent for diagnostic category O, under part 9500.1100, subpart 20 to determine the per day rate for the diagnostic category;

(4) subtract the day outlier trim point for the appropriate diagnostic category from the actual number of days a recipient has received inpatient hospital services to determine the number of outlier days; and

(5) multiply the product determined in subitem (3) by the number of days determined in subitem (4).

B. To determine reimbursements for cost outliers the department shall:

(1) determine a statewide base year cost-to-charge ratio according to hospitals' statewide base year medicare/medical assistance cost reports for all medical assistance admissions combined;

(2) multiply the hospital's billed charges by the statewide cost-to-charge ratio;

(3) subtract the cost at three standard deviations for diagnostic category W, under part 9500.1100, subpart 20 and at one standard deviation for diagnostic category O, under part 9500.1100, subpart 20 as identified in part 9500.1110, subpart 1, item H from the adjusted cost from subitem (2); and

(4) multiply the difference determined in subitem (3) by 60 percent for diagnostic category W, under part 9500.1100, subpart 20 or by 80 percent for diagnostic category O, under part 9500.1100, subpart 20.

C. If an admission is a day and a cost outlier, a hospital shall receive reimbursement as a day outlier.

Subp. 10. **Reimbursement to an out-of-area hospital.** The department shall reimburse an out-of-area hospital for an admission based on the lesser of billed charges for the admission or either the out-of-area hospital categorical rate per admission or the transfer reimbursement and outlier reimbursement if appropriate. The department shall determine the out-of-area categorical rate per admission as follows in items A to G:

A. multiply the adjusted base year cost per admission in effect on the first day of a calendar year for each hospital statewide by that hospital's HCI and by the number of admissions in that hospital's base year, including outliers;

B. sum the products in item A;

C. divide the sum from item B by the sum of all admissions for all hospitals statewide, including outliers, to determine the statewide budget year adjusted allowable base year cost per admission;

D. multiply the pass-through cost per admission in effect on the first day of a calendar year for each hospital statewide by the number of admissions in each hospital's base year, including outliers;

E. sum the products in item D;

F. divide the sum from item E by the sum of all admissions for all hospitals statewide, including outliers, to determine a statewide pass-through cost per admission;

G. the department shall determine the categorical rate per admission for an out-of-area hospital as follows:

Out-of-area Hospital Categorical Rate Per Admission	=	[(statewide budget year adjusted base year cost per admission multiplied by the relative value of the appropriate diagnostic category), plus statewide budget year pass-through cost per admission]

Subp. 11. **Reimbursement for MSA and non-MSA hospitals statewide that do not have admissions in the base year.** The department shall determine reimbursements for MSA hospitals statewide that do not have admissions in the base year according

to items A to E:

A. Multiply the adjusted base year cost per admission in effect on the first day of a calendar year for each MSA hospital statewide by that hospital's budget year HCI by the number of admissions in each MSA hospital's base year, including outliers.

B. Sum the products in item A.

C. Divide the sum from item B by the sum of the admissions for all MSA hospitals statewide, including outliers, to determine the statewide allowable base year cost per admission for MSA hospitals.

D. The budget year pass-through cost per admission must be determined according to part 9500.1125, subpart 2. The pass-through cost per admission will be adjusted under part 9500.1125, subpart 4, and must be subject to part 9500.1125, subpart 4, item H.

E. Determine the categorical rate per admission for MSA hospitals statewide as follows:

Categorical Rate per Admission for MSA Hospitals Statewide That Do Not Have Admissions In The Base Year	=	[(adjusted base year cost per admission for MSA hospitals statewide multiplied by the budget year HCI and multiplied by the relative value of the appropriate diagnostic category) plus budget year pass-through cost per admission]

F. Determine the categorical rate per admission for non-MSA hospitals by substituting non-MSA hospitals terms and data for the MSA hospitals terms and data used in items A to E.

Subp. 12. Payor of last resort. A hospital may not submit a claim to the department until a final determination of the recipient's eligibility for potential third party payment has been made by a hospital. Any and all available third party benefits must be exhausted prior to billing medical assistance and the amounts collected must be shown on the claim.

MS s 256.969 subds 2,6

10 SR 227; 10 SR 867; 11 SR 1688; 13 SR 1689

9500.1135 DISPROPORTIONATE POPULATION ADJUSTMENT.

Subpart 1. Determination of disproportionate population adjustment. The department shall increase the adjusted base year cost per admission for hospitals whose medical assistance and general assistance medical care admissions during the base year, including admissions of recipients who are also eligible for medicare and excluding admissions of participants in a prepaid health plan, exceed 15 percent of total hospital admissions.

The department may redetermine disproportionate population adjustments using its own claims payments data, data reported by hospitals on medicare or medical assistance cost reports or data reported by hospitals on their pass-through cost reports.

The department may make this redetermination if the percentage of a hospital's MA or GAMC admissions, excluding admissions of participants in a prepaid health plan, changes enough to decrease or increase a hospital's adjusted base year cost per admission according to the four percentage categories

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in the schedule below.

Percentage of Total Hospital Admissions Which are MA and GAMC, and Recipients Who are Also Eligible for Medicare	Increase in Adjusted Base Year Cost Per Admission
15-20 percent	1/4 percent for each percentage point above 15 percent up to 20 percent
21-25 percent	1/2 percent for each percentage point above 20 percent up to 25 percent
26-30 percent	3/4 percent for each percentage point above 25 percent up to 30 percent
31 percent and above	1 percent for each percentage point above 30 percent

The department shall multiply the disproportionate population adjustment by the adjusted base year cost per admission after the application of any statutory limits to the growth in hospital rates or unit costs.

Subp. 2. **Limitation on disproportionate population adjustment.** In no case shall the disproportionate population adjustment exceed twice the HCI as determined in part 9500.1120.

MS s 256.969 subds 2,6

10 SR 227; 11 SR 1688

9500.1140 APPEALS.

Subpart 1. **Appeals board.** The commissioner shall appoint an appeals board to review hospitals' requests for changes in their reimbursement rates. The appeals board shall consist of two public representatives, two representatives of the hospital industry, and one representative of the business or consumer community. Any hospital that desires to have its rate reviewed by the appeals board shall submit to the commissioner a written request which states the rate and reasons for the request. Within 90 days of the request, the appeals board shall meet with persons selected by the hospital and persons from the department. The appeals board shall make a written report and recommendation to the commissioner. The commissioner shall issue a written decision on the request for a change in the hospital's rate within 30 days after receiving the report of the appeals board.

Subp. 2. **Contested case hearing.** A hospital may appeal a decision of the commissioner issued pursuant to subpart 1, by filing a written notice of appeal with the commissioner within 30 days of the date of service of the decision appealed. The appeal must be conducted as a contested case hearing under Minnesota Statutes, chapter 14 and the rules of the Office of Administrative Hearings.

MS s 256.969 subds 2,6

10 SR 227

9500.1150 REIMBURSEMENT OF ADMISSIONS FOR HOSPITAL FISCAL YEARS BEGINNING ON OR AFTER JULY 1, 1983, UNTIL JULY 29, 1985.

Subpart 1. **Statutory limit.** Under Minnesota Statutes, section 256.969, the annual increase in the cost per service unit for inpatient hospital services under medical assistance or

general assistance medical care shall not exceed five percent for hospital rate years beginning during the 1985 biennium.

Subp. 2. **Definitions.** As used in this part, the following terms have the meanings given to them.

A. "Adjusted base year costs" means an allowable base year costs cumulatively multiplied by the hospital cost index through a hospital's current year, and adjustments resulting from appeals.

B. "Allowable base year costs" means a hospital's reimbursable inpatient hospital costs as identified in a hospital's base year medicare/medical assistance cost report with the following adjustments:

(1) subtract malpractice insurance costs that have been apportioned to medical assistance;

(2) subtract pass-through costs (except malpractice insurance costs) apportioned to medical assistance based on the ratio of net reimbursable inpatient hospital costs to total reimbursable costs; and

(3) add the lower of cost or charge limitations for costs disallowed on the medicare/medical assistance cost report as provided by Public Law Number 92-603, section 223, inpatient routine service cost limitations, and Public Law Number 92-603, section 233.

C. "Minimal participation" means a hospital with fewer than 100 combined medical assistance and general assistance medical care admissions in the base year.

D. "Rate per admission" means the adjusted base year cost for each admission multiplied by the budget year HCI and adding the budget year pass-through cost per admission.

E. "Rate per day" means the adjusted base year cost per day of inpatient hospital services multiplied by the budget year HCI and adding the budget year pass-through cost per day of inpatient hospital services.

Subp. 3. **Determination of allowable base year costs, allowable base year cost for each admission, and allowable base year cost per day.** The department shall determine allowable base year costs from the base year medicare/medical assistance cost report, using data from the HCFA Form 2552 Worksheet, 1981 revision. The department shall make the determination following the steps outlined in items A to P:

A. reimbursable inpatient hospital costs (Worksheet E-5, Part I, line 13);

B. reimbursable malpractice insurance costs (Worksheet E-5, Part I, line 5);

C. reimbursable professional services (Worksheet E-5, Part I, line 11);

D. net reimbursable inpatient hospital costs (subtract items B and C from item A);

E. total reimbursable costs (Worksheet A, column 7, line 84);

F. ratio of net reimbursable inpatient hospital costs to total reimbursable costs (item D divided by item E);

G. pass-through costs, except malpractice insurance costs;

H. medical assistance pass-through costs, except malpractice insurance costs (item F multiplied by item G);

I. routine service costs before limitation (Worksheet D-1, line 57);

J. reimbursable routine service costs (Worksheet D-1, line 61);

K. reimbursable routine service costs subject to limitation (subtract item J from item I);

L. allowable base year costs (subtract item H from item D and add item K);

M. base year admissions excluding medicare crossovers;

N. allowable base year cost for each admission (item L divided by item M);

O. base year patient days excluding medicare crossovers; and

P. allowable base year cost per day (item L divided by item O).

Subp. 4. **Determination of rate per admission and rate per day.** The department shall determine the rate per admission and rate per day according to items A to G.

A. For each hospital's budget year, each hospital shall submit to the department a written report of pass-through costs. Pass-through cost reports must include actual data for the prior year and budgeted data for the current and budget years. Pass-through cost reports are due 60 days prior to the start of each hospital's budget year and must include the following information:

Subitem	Prior Year (Actual)	Current Year (Budget)	Budget Year (Budget)
(1) Depreciation			
(2) Rents and leases			
(3) Property taxes			
(4) License fees			
(5) Interest			
(6) Malpractice insurance			
(7) Total Pass-Through Costs [subitems (1) to (6)]			

Pass-through costs are limited to subitems (1) to (6) as defined by medicare. Pass-through costs do not include costs derived from capital projects requiring a certificate of need for which the required certificate of need has not been granted.

B. The department shall determine the budget year pass-through cost per admission or per day, or both, from the submitted pass-through cost reports as specified in item A as follows:

Subitem	Prior Year (Actual)	Current Year (Budget)	Budget Year (Budget)
(1) Ratio of net reimbursable inpatient hospital costs to total reimbursable costs [subpart 3, item F]			